APPENDIX H

Forms Related to Continuity of Care

COMMONWEALTH OF VIRGINIA
DEPARTMENT OF MENTAL HEALTH, MENTAL RETARDATION AND SUBSTANCE ABUSE SERVICES

WARRANT

Sections 37.1-76, 37.1-126, 16.1-246 Code of Virginia

_____
Facility

_____ Virginia _____ 19 ____

COMMONWEALTH OF VIRGINIA

County/City of _____ to wit:

To Sheriff/Police Department of
City or County of _____

WHEREAS, _____ Reg. No. _____
Name of Patient/Resident SSN _____

formerly confined in the _____
Name of Facility Address

Virginia, did escape from said facility on _____ 19 ___ or was released on temporary pass or convalescent leave and said pass or convalescent leave was revoked by the Director on _____ 19 ____

These are, therefore, in the name of the Commonwealth of Virginia, to command you forthwith to apprehend the body of the said _____ and deliver him/her into the custody of _____
Name of Patient/Resident

at _____

Signed: _____
Physician

Signed: _____
Director or Designee

PATIENT/RESIDENT DESCRIPTION:

Race ____ Sex ____ Age/DOB _____ Height Weight ____Hair Eyes

Special physical features/Identifying Marks: _____

Date, Time, Place Last Seen: _____

Patient Last Seen Wearing: _____

Special Behaviors/Risk Factors (check if known):

Suicidal Homicidal __ Vulnerable __ Dangerous Medical Complications: _____

Assistive Devices, i.e., eye glasses, hearing aid, cane, etc. _____

Last Known Address: _____ Present Location: _____
Tel #

State Police Notified: Does Patient Speak English?

Warrant No: _____ Yes ___ No

Warrant Called In At: To: _____ Picked Up At: By: _____

PREADMISSION SCREENING FORM

The Preadmission Screening Form is to be completed by qualified professionals designated by the Community Services Board for individuals who have been found to meet criteria for voluntary or involuntary admission to a state psychiatric hospital. Please refer to the **Guidelines for Mental Health and Substance Abuse Preadmission Screening and Discharge Planning.** Also attach the Geriatric Prescreening Supplement or the Child and Youth Prescreening Supplement when indicated.

I. Personal Data

Name _____ Age DOB

Address _____
Street City or County Zip

Sex Marital Status _____

Social Security No. _____

Occupation/Employer _____ Monthly Income _____

SSI or SSDI $ _____ Payee _____

Hospitalization Insurance Co. _____

Veteran _____ Yes _____ No

Medicaid Benefits _____ Yes _____ No _____ Unknown

Medicare Benefits _____ Yes _____ No _____ Unknown

In Case of Emergency, Notify _____
Name

_____
Street City or County State Zip

Phone (___) _____ Relationship to Client _____

Case Management CSB _____ PRAIS CASEMGT CSB Code ☐☐☐☐

Case Management CSB Contact _____

II. Clinical Assessment: Identify behaviors or symptoms indicating mental illness and elaborate in the space provided

___ paranoia	___ grandiose	___ bizarre behavior	___ sleep disturbance	___ suicidal ideation
___ delusions	___ poor self care	___ loose associations	___ withdrawn	___ flight of ideas
___ disoriented	___ hallucinations	___ impaired judgement	___ depressed	___ pressured speech
___ agitated	___ impaired impulse control	___ appetite disturbance	___ anxiety	___ homicidal ideation

_____

_____

_____

_____

Precipitating events and/or stressors

_____

_____

_____

_____

Drugs or controlled substances which are abused by the client and pattern of abuse

_____

_____

_____

_____

Documentation of Need for Voluntary Hospitalization: Check appropriate criteria for voluntary or involuntary hospitalization and describe specific behaviors which document this conclusion in the space provided.

____ A By reason of mental illness or substance abuse, the client is dangerous to self or others
____ B By reason of mental illness or substance abuse, the client is unable to care for self (i.e., unable or refuses to accept interventions which would meet minimum needs for food, clothing, shelter)
____ C By reason of mental illness, the client is suffering or is likely to suffer substantial deterioration in ability to function if not treated immediately
____ D The Community Services Board is unable to provide treatment, continuous supervision, monitoring, or protection in a community-based treat modality

_____

_____

_____

RECOMMENDATIONS

The client is in need of hospitalization and is either unwilling to accept voluntary inpatient treatment or is incapable of making an informed decision regarding such treatment

B The client is in need of hospitalization and is willing to accept voluntary inpatient treatment and is capable of making an informed decision regarding such treatment

C The client does not meet criteria for hospitalization and/or commitment and will be encouraged to participate in community-based services. Services to be offered would include:

_____

_____

_____

_____

IV. Legal Data

Are there criminal charges pending against individual? ___ Yes ___ No ___ Unknown

Nature of charges. _____

Date of hearing if known. _____ Location _____

Is individual serving a sentence? ___ Yes No Unknown

Subject to a court order? ___ Yes ___ No

Name of committee or guardian if known _____
Name

_____
Address Phone

V. Current or Previous Treatment History

Identify current service providers (i.e. CSB, CSB contractual agency, private provider, etc.) and services and/or treatment being provided:

	Service Provider	Services/Treatment Provided
1.	_____	_____
2.	_____	_____
3.	_____	_____

Diagnosis (DSM III) if known or provisional diagnosis

Axis I _____

Axis II _____

Medical problems _____

_____

_____

Current prescribed medications (include dosage, schedule, etc.)

_____

_____

Known allergies or adverse side-effects to medications _____

_____

Has client complied with recommended treatment plans? Yes No

If no, describe nature of non-compliance _____

_____

Previous inpatient treatment (facilities, length of hospitalization) _____

_____

_____

VI. Treatment and Discharge Planning

Individuals who can assist in treatment and discharge planning (i.e. family, case manager, therapist, family physician, etc.) .

Name	Phone #	Relationship to Client
3.		

Inpatient treatment recommendations and goals _____

_____

_____

_____ _____

Anticipated length of hospitalization _____

Current living situation _____

Recommended living situation on discharge

_____

_____

Services to be considered in planning for discharge

_____ medication management
_____ psychosocial/day treatment
_____ case management
_____ psychotherapy (individual, family, group)
_____ substance abuse services
_____ mental retardation services
_____ housing/residential services
_____ financial support/entitlements
_____ adult or child protective services
_____ medical/dental/nutritional services
_____ legal assistance/advocacy
_____ transportation
_____ vocational/educational training
_____ employment services
_____ recreational/social opportunities
_____ nursing home care

_____ Other: _____

_____

Identify persons who provided information for this assessment and their relationship to the client

_____

_____

_____

Client's primary therapist or case manager: _____

_____ _____
Signature of Prescreener Prescreening Agency or Board

_____ _____
Print Name Here Date

_____ _____
Signature of Physician (if a physician is available and the client is under 21 and Medicaid eligible) Facility or Agency/Board

_____ _____
Print Name Here Date

. hereby authorize _____ and _____
Community Services Board(s) State Facility(s)

to exchange information to be used in treatment and discharge planning to meet my needs as identified during the course of my hospitalization and follow-up referral. This information will include, but not be limited to, my participation in aftercare programs, my work experience, my family relationships, my treatment history, and an assessment of my overall general health. The release of such information may be verbal, written, or copies of portions of my records.

_____ _____
Signature of Client or his/her Guardian Date

_____ _____
Signature of Witness Date

Check the following if applicable

_____ The client or authorized representative refuses to give consent for the exchange of information described above.

_____ The client is unable to give informed consent for the exchange of information described above.

_____ The judge will be requested to order the exchange of information described above.

_____ The client or authorized representative has been informed that information can be exchanged under court order or Section 37.1-98.2

DMH Form 1006-B 11/87
Approved by the Attorney General

COMMONWEALTH OF VIRGINIA

DEPARTMENT OF MENTAL HEALTH, MENTAL RETARDATION AND SUBSTANCE ABUSE SERVICES

APPLICATION FOR VOLUNTARY ADMISSION TO A STATE HOSPITAL OR OTHER FACILITY IN VIRGINIA

PURSUANT TO SECTION 37.1-67.2, CODE OF VIRGINIA (1950), as AMENDED

TO: The Director _____
(Insert name of Hospital or other Facility)

At _____

I, _____, hereby apply for admission as a
(Name of applicant)

voluntary patient for care and treatment as _____
(Indicate whichever is applicable. Mentally Ill, Mentaly Retarded, Alcoholic or Drug Addict)

and I agree to hospitalization and treatment in the aforementioned facility for 72 hours, unless sooner discharged by the director. Furthermore, I agree to give the facility 48 hours notice of my desire to leave and to remain in the facility during this notice period unless sooner discharged by the director.

Signed _____
Patient

Co-Signed _____
Parent or Guardian, if patient is a minor

The applicant appeared before me this _____ day of _____, 19 _____ and, as required by law, has agreed to accept voluntary admission and treatment at the aforementioned facility under the above terms and conditions.

_____
Judge or Special Justice

(Type or Print)

Name _____

Title _____

Address _____

PATIENT'S ADMISSION INFORMATION

DATE _____ ADDRESS _____
Street, Route No.

_____ _____ _____ _____
City or County | Post Office | State | Zip Code

Race _____ Birth Date _____ Sex _____

I, the Director or authorized admitting physician, certify that the provisions regarding the rights of a voluntary patient have been explained and the above named applicant is accepted as a voluntary patient.

Signed _____
Director or Admitting Physician

Date Admitted _____ 19____ Hour _____ a.m./p.m.

Register Number _____

Commonwealth of Virginia

DEPARTMENT OF MENTAL HEALTH, MENTAL RETARDATION AND SUBSTANCE ABUSE SERVICES

PROCEEDINGS FOR CERTIFICATION FOR INVOLUNTARY ADMISSION TO A PUBLIC or PRIVATE LICENSED MENTAL HEALTH FACILITY

PURSUANT TO §§ 37.1 - 67.1 through 37.1 - 67.3, Code of Virginia (1950), as amended.

City
County of _____

To wit:

PETITION

General District Court City

To the Judge or Special Justice of the Juvenile and Domestic Relations District Court of the County

of _____

In the matter of _____ _____ _____
Given Name Middle Name(s) Surname

Soc. Security No. _____ Birth Date _____ Sex Permanent Address _____
St. & Number or Route No

_____ _____ _____
City or Post Office State Zip Code

Legal Resident* of _____ County _____ City

a person alleged to be _____
Indicate whichever applies: Mentally Ill, Alcoholic, Drug Addict

who is now in the care of _____ _____ _____
Name Address Relationship

The undersigned petitioner alleges that the above person is mentally ill and in need of hospitalization. In support of the allegation, the petitioner, _____ submits the following facts:

☐ Prescreening evaluation has been made and the report recommending hospitalization is attached.

Wherefore, your petitioner prays that the said _____ be examined and accorded such assistance provided by law.

Date _____ 19____ SIGNED _____

Relation to person _____ Address _____

Phone number _____ If public officer, give title _____

The foregoing petitioner, being duly sworn, deposes and says that the statements set forth above are true and correct to the best of his knowledge and belief.

Subscribed and sworn to before me on this _____ day of _____, 19____.

_____
Judge, Special Justice, or Notary Public

_____ _____
Print Name Phone Number

Commission expires on _____, 19____ Title _____

*§ 37.1-1 (12) "Legal Resident" of Virginia means any person who is a bona fide resident of the Commonwealth of Virginia.

PRINT or TYPE ALL INFORMATION EXCEPT WHERE SIGNATURES ARE REQUIRED.

PREPARE AND SEND TO THE STATE HOSPITAL OR OTHER FACILITY TO WHICH PATIENT IS ADMITTED.

GENERAL INFORMATION

Place of Birth _____

Marital status: Single _____ Married _____ Widowed _____ Divorced _____

Separated _____ Unknown _____

Race _____

Religion: Protestant _____ Catholic _____ Jewish _____ Other _____ Unknown _____

Occupation _____

Nearest Relative or Correspondent _____
Name Address Telephone No. Relationship

PHYSICIAN'S EXAMINATION

Mental information:

State briefly mental symptoms of patient: _____

_____

_____

_____

When first observed _____ How rapid development _____

Has patient attempted suicide: Yes _____ No _____ If yes—explain _____

_____

Has patient attempted homicide: Yes _____ No _____ If yes—explain _____

_____

If mentally retarded, state intellectual level, if available _____

Has patient had previous psychiatric care? Yes _____ No _____ Unknown _____

If yes — name hospital, clinic or private psychiatrist

_____
Name Address

_____
Name Address

_____
Name Address

Alcoholic habits (state briefly, if known) _____

Drug habits (state briefly, if known) _____

Physical information:

State briefly any present or recent physical disease, illness or injury _____

_____

_____

Is patient on medication? Yes No _____ If yes—what _____

_____

_____

_____

A. COMMONWEALTH OF VIRGINIA

City
County of _____

I, the undersigned physician, do certify that I have this day personally examined the person named in the foregoing petition and as the result of such examination have sufficient cause to believe that he (is/is not) mentally ill; that he (does/does not) present an imminent danger to (himself/others), or (is/is not) substantially unable to care for himself, as a result of mental illness; and that he (does/does not) required involuntary hospitalization. Further, I am not related by blood or marriage to the individual on whom the petition is filed and have no interest in his estate.

Given under my hand this _____ day of _____

19____

_____ Address

_____ Doctor of Medicine (type/print)

_____ Signature

NOTE:
This certification of examination shall not be accepted or used as evidence at any hearing under § 37.1-67.3 of the Code of Virginia (1950), as amended, UNLESS such examination be made within the five (5) days immediately preceding such hearing and provided there is no objection to the acceptance of same by the person or his attorney.
The positive certification of at least one physician is necessary to commit the person named in the petition.

B. I certify that upon the appearance before me of the person named in the petition, on this _____ day of _____ 19____, I informed him of his right to make application for voluntary admission and treatment as provided for in §37.1-65, his right to a full and impartial hearing in the event that he should refuse to make application for voluntary admission, his right to representation by counsel, the basis for his detention, the standard upon which he may be detained, his right to appeal such hearing to the circuit court, and his right to a jury on appeal. I then ascertained if he was represented by counsel.

(Check One)
- ☐ A voluntary admission requested (complete DMH Form 1006-B)
- ☐ A hearing requested
- ☐ A hearing required due to incapacity to consent to voluntary admission and treatment

(Check One)
- ☐ Represented by counsel of own choosing
- ☐ Counsel appointed

_____ Judge or Special Justice

Title _____

C. I certify that I, an attorney-at-law, served as counsel for the person named in the foregoing petition, that I interviewed such person and all witnesses, if any, in his behalf, prior to any hearing, and that after my employment or appointment as counsel, I did represent the person named in the foregoing petition at all proceedings conducted by the judge or special justice pursuant to the foregoing petition.

_____ Counsel

_____ Address

Subscribed and sworn to before me this _____ day of _____, 19 _____

_____ Judge or Special Justice

Title _____

D. (Execute only if hearing requested.)
I hereby certify that the person named in the foregoing or the attorney-at-law representing such person requested a hearing on the question of his admission. Such hearing was held on this _____ day of _____ 19____ and the following witnesses were summoned:

Name	Address	Relationship

_____ Judge or Special Justice

Title _____

CERTIFICATION AND ORDER FOR INVOLUNTARY ADMISSION TO A PUBLIC OR LICENSED PRIVATE FACILITY

COMMONWEALTH OF VIRGINIA

City
County of _____

To the sheriff or other authorized officer of said county or city and to the director of

_____ _____
Facility Address

Greetings:
WHEREAS, _____ Judge or Special Justice of _____

court of the said county or city have observed the person named in the foregoing petition, alleged to be in need of care and treatment in a hospital, and have reviewed the medical certifications and statement of facts upon which such certifications are based and have this day found that the person named in the foregoing petition:

- ☐ 1. Presents an imminent danger to himself as a result of mental illness.
- ☐ 2. Presents an imminent danger to others as a result of mental illness.
- ☐ 3. Has otherwise been proved to be so seriously mentally ill as to be substantially unable to care for himself.

Furthermore: (check one and complete)

☐ A. The alternatives to involuntary hospitalization and treatment were investigated and were deemed suitable. I have found that there is a less restrictive alternative to involuntary hospitalization and treatment in this case. I, therefore, direct that the person named in the foregoing petition receive treatment in accord with the following order:

_____

_____

_____

☐ B. The alternatives to involuntary hospitalization and treatment were investigated and were deemed unsuitable. I have found that there is no less restrictive alternative to involuntary hospitalization and treatment in this case.

I, therefore, command you, the said sheriff, other authorized officer or responsible person, to make provision for the suitable and proper care of the person named in the foregoing petition and to deliver such person to the director of _____

_____

_____ for involuntary hospitalization and treatment not to
Address

exceed 180 days from this date. Furthermore, if admission is denied pursuant to §§37.1-68 or 37.1-70, you are hereby authorized to return the person named in the foregoing petition to this jurisdiction.

Given under my hand and and seal this _____ day of _____ 19_____

_____
Judge or Special Justice

Name _____

Title _____

Type or Print

Address _____

DISCHARGE PLAN AND REFERRAL SUMMARY

(To be Completed at Time of Discharge)

Patient's Full Name _____ Hospital No. _____
SSN _____ Age _____ Insurance/VA Benefits _____
Date of Admission _____ Admitting CSB _____
Date of Discharge _____ Discharge CSB _____
Name and Address of Correspondent _____
_____
_____ Phone _____

• • • • • •

Patient's Discharge Address _____
_____
_____ Phone _____
Type of Placement/Facility _____
Residential Placement Code (Refer to ARS Residential Placement Codes) _____

• • • • • •

Referral to CSB Mental Health Services? ____ Yes ____ No If No, Why? _____
_____
CMHC and Address _____
_____
_____ Phone _____
Date and Time of Appointment _____
Appointment With (Name of CMHC Personnel) _____
Appointment Confirmed by (Name of Hospital Personnel) _____ Date _____
Other Scheduled Referrals (Include Agency, Date, Time, Name of Personnel)
_____
_____
Other Recommendations/Information _____
_____
_____
Signed Authorization(s) to Release Information: ____ Yes ____ No

• • • • • •

Discharge Diagnosis: Axis I _____
Axis II _____
Axis III _____
Axis IV _____
Axis V _____
Condition: _____ Recovered _____ Not Recovered, Improved
_____ Unimproved _____ Not Mentally Ill
Medication at Discharge (Types and Regimen) _____
_____
_____
Supply Given: _____ Days Pharmacy Card Mailed (Date) _____
Special Instruction/Other Recommendations/Information _____
_____
_____
_____
_____

_____ Date _____
M.D. Signature

COMMUNITY SERVICE AND SUPPORT NEEDS

(To Be Completed at Time of Discharge)

Patient's Full Name _____ Hospital No. _____
Date of Discharge _____ Discharge CSB _____
Name and Address of CSB Case Manager _____
_____
_____ Phone _____

• • • • • •

In the designated spaces in the columns below, please indicate those community services and supports which are (a) needed by the patient upon discharge, and (b) available to the patient in the community, if needed. Also indicate (c) whether the patient at discharge is willing to use the services needed and (d) whether the patient, if willing, also has the means and/or capability to access and utilize the services needed. Lastly, indicate (e) if a referral or application has been initiated for the service needed.

Please enter "1" if yes and "2" if no, in the corresponding spaces as appropriate.

Services	Patient Needs at Discharge				
	(a) Needs	(b) Available	(c) Willing To Use	(d) Capable Of Using	(e) Referral Initiated
CSB Core Services					
Emergency/Crisis Intervention					
Inpatient Mental Health Care					
Outpatient Services					
Counseling/Psychotherapy					
Case Management					
Medication					
Day Support Services					
Day Treatment/Partial Hosp.					
Psychosocial Rehabilitation					
Other: _____					
Residental Services					
Type: _____					
Other CSB Services					
Mental Retardation Services					
Substance Abuse Services					
Non-CSB Services					
Financial/Soc. Services Entitlements					
SSI/SSDI					
Auxiliary Grant					
Food Stamps					
Medicaid/Medicare					
Other: _____					
Medical					
Dental					
Other Residential					
Type: _____					
Vocational/Education					
Type: _____					
Nutritional					
Type: _____					
Transportation					
Legal/Advocacy					

COMMUNITY SERVICE AND SUPPORT NEEDS (Continued)

Patient's Full Name _____ Hospital No. _____

Discharge Plan: In the space below, describe the community service and support plans which have been initiated and/or completed to meet the patient's identified needs as shown on Part 2, Page 1. Indicate responsible providers, dates, etc., for all planned services and supports, and status of plans in process. Describe plans/strategies where appropriate to facilitate service delivery to patients where patient is unwilling or unable to access services.

_____ Date _____
Signature/Authorization for Facility

_____ Date _____
Signature/Authorization for CSB

• • • • • •

I, the undersigned, have reviewed and understand the arrangements and recommendations described in Parts 1 and 2 of this document. I also understand that this document will be transmitted to the CSB serving the locality to which I am being discharged.

_____ Date _____
Signature/Authorization of Patient